SUPERVISED PRACTICE DOCUMENTATION (POST MASTERS)
FOR
ARKANSAS BOARD OF EXAMINERS IN COUNSELING

Must be professional work completed after the transcript date the Masters Degree was conferred.

Applicant: _____SSN: _____

Supervisor: _____ Length of Supervision: _____

Dates from _____ to _____

Total Client Contact Hours: _____ Total Supervised Hours: _____

CCH worked per week: _____ SH per week: _____

Work Setting and Title during Documented Supervised Practice:

Supervisor: _____

Applicant: _____

Describe the Categories of Counseling Contacts: _____

I VERIFY THE INFORMATION ABOVE AS ACCURATE FOR THE APPLICANT

Supervisor's Signature: _____ Date: _____

Print Supervisor's name: _____Title: _____

Supervisor's Phone # _____ Institution: _____

Supervisor's address: _____

Do you (Supervisor) hold a license or certificate to practice as one of the following?

- Counselor
- Therapist
- Psychologist
- Other: _____

License or Certificate Number: _____ Expiration Date: _____

Return this form directly to: ***Arkansas Board of Examiners in Counseling***
P.O. Box 70
Magnolia, AR 71754-0070